

Medication List

Patient Name: _____

Date: _____

	Medication Names	Doseage	Prescribing Physician
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____
8	_____	_____	_____
9	_____	_____	_____
10	_____	_____	_____

<u>Review of Systems</u>			
<u>Constitutional</u>			
Weight changes	<input type="checkbox"/>	<u>Respiratory</u>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	Wheezing/Asthma	<input type="checkbox"/>
<u>Cardiovascular</u>		Chronic cough	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<u>Hematologic/Lymphatic</u>	
Palpitations	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>
Swelling hands/Feet	<input type="checkbox"/>	Slow to heal	<input type="checkbox"/>
<u>Endocrine</u>		Enlarged glands	<input type="checkbox"/>
Excessive thirst	<input type="checkbox"/>	<u>Integumentary (Skin/breasts)</u>	
Thyroid disease	<input type="checkbox"/>	Breast lump/Mass	<input type="checkbox"/>
hormone imbalance	<input type="checkbox"/>	Breast pain/Discharge	<input type="checkbox"/>
<u>Neurological</u>		Changes in lesions/Moles	<input type="checkbox"/>
Frequent headaches	<input type="checkbox"/>	<u>Genitourinary</u>	
Convulsions/Seizures	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>
Numbness/Tingling	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>
<u>Gastrointestinal</u>		Painful unnaion	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	Menstruai problems	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	Testicle pain	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<u>Ears/Nose/Mouth/Throat/Eyes</u>	
Rectal bleeding	<input type="checkbox"/>	Hearing loss/Ringing	<input type="checkbox"/>
Black tarry stools	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	Glasses/Contacts	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	Blurred/Double vision	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	Eye disease/Injury	<input type="checkbox"/>
		Glaucoma	<input type="checkbox"/>